BROOKE ARMY MEDICAL CENTER/WILFORD HALL MEDICAL CENTER
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR RESEARCH
(APHI Template Version 3, February 04)

You are being asked for permission to use or disclose your protected health information for research purposes in the research study entitled [*Insert title of study here and in header pg2*].

The Health Insurance Portability & Accountability Act of 1996, Public Law 104-109 (also known as HIPAA), establishes privacy standards to protect your health information. This law requires the researchers to obtain your authorization (by signing this form) before they use or disclose your protected health information for research purposes in the study listed above.

Your protected health information that may be used and disclosed in this study includes:

- [*Demographic Information for example age, sex, race, etc*.]
- [*Medical History/Surgical History*]
- [*Imaging Studies, Laboratory Results*]
- [*Other: List all other information that may be accessed, disclosed or otherwise included in research activities*.]

Your protected health information will be used for:

- [*In an 8th grade reading level, provide a brief description of each research project or paste information from the purpose section in the consent form*.]

The disclosure of your protected health information is necessary in order to be able to conduct the research project described. Records of your participation in this study may only be disclosed in accordance with state and federal law, including the Privacy Act (5 U.S.C. 552a) and the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. 160 & 164). Note: Protected health information of military service members may be used or disclosed for activities deemed necessary by appropriate military command authorities to ensure the proper execution of the military mission.

By signing this authorization, you give your permission for information gained from your participation in this study to be published in medical literature, discussed for educational purposes, and used generally to further medical science. You will not be personally identified; all information will be presented as anonymous data.

The Principal Investigator may use and share your health information with:

- The BAMC/WHMC Institutional Review Board

- State and Federal Government representatives, when required by law
- BAMC, WHMC or Department of Defense representatives
- [*List any collaborators, outside laboratories, etc., AND what each is, i.e., research collaborator or outside laboratory, etc.*]
- [*If applicable -list the sponsor's name, AND what it is, i.e., pharmaceutical manufacturer or medical device manufacturer, etc*]
- [*List any other groups with whom the information may be shared, AND what that group is*]

The researchers [*and list sponsor's name, foundations, etc if applicable*] agree to protect your health information by using and disclosing it only as permitted by you in this Authorization and as directed by state and federal law.

You need to be aware that some parties receiving your protected health information may not have the same obligations to protect your protected health information and may re-disclose your protected health information to parties not named here. If your protected health information is re-disclosed, it may no longer be protected by state or federal privacy laws.

You do not have to sign this Authorization. If you decide not to sign the Authorization:

- It will not affect your treatment, payment or enrollment in any health plans or affect your eligibility for benefits.
- You may not be allowed to participate in the research study.

After signing the Authorization, you can change your mind and:

- Notify the researcher that you have withdrawn your permission to disclose or use your protected health information (revoke the Authorization).
- If you revoke the Authorization, you will send a written letter to [*Principal Investigator's name and contact information*] to inform him/her of your decision.
- If you revoke this Authorization, researchers may only use and disclose the protected health information already collected for this research study.
- If you revoke this Authorization your protected health information may still be used and disclosed should you have an adverse event (a bad effect).
- If you withdraw the Authorization, you may not be allowed to continue to participate in the study.

[Note: the following paragraph must be included if the protocol is blind, or the early release of participant's information would adversely effect the study.]

During your participation in this study, you will not be able to access your research records. This is done to ensure the study results are reliable. After the completion of the study, you have

the right to see or copy your research records related to the study listed above. A Request for Access must be made in writing to [*Principal Investigator's name and contact information*]

If you have not already received a copy of the brochure entitled "Military Health System Notice of Privacy Practices," you may request one. DD Form 2005, Privacy Act Statement - Military Health Records (located on your medical records jacket), contains the Privacy Act Statement for the records. If you have any questions or concerns about your privacy rights, you should contact the Brooke Army Medical Center Privacy Officer at phone number (210) 916-1029 or Wilford Hall Medical Center Privacy Officer at (210) 292-4599.

This Authorization does not have an expiration date.

You are the subject or are authorized to act on behalf of the subject. You have read this information, and you will receive a copy of this form after it is signed.

_____	_____	_____
Volunteer's Signature or Legal Representative	**Volunteer's SSN**	**Date**
_____	_____	
Volunteer's Printed Name or Legal Representative	**Sponsor's SSN**	

_____

Relationship of Legal Representative to Volunteer

_____	_____
Signature of Witness	**Date**